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HL-2229
003470

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U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D.C. 20555

PLANT HATCH - UNITS 1, 2
NRC DOCKETS 50-321, 50-366
OPERATING LICENSES DPR-57, NPF-5
REPLY TO A NOTICE OF VIOLATION

Gentlemen:

In response to your letter of April 30, 1992 and in accordance with the provisions of 10 CFR 2.201, Georgia Power Company (GPC) is providing the enclosed response to the Notice of Violation associated with Inspection Report 92-08. A copy of this response is being provided to NRC Region II for review. In the enclosure, a transcription of the NRC violation precedes GPC's response.

Should you have any questions, please contact this office.

Sincerely,

J. T. Beckham, Jr.

JKB/cr

Enclosure

cc: (See next page.)

IE01
1/1

cc: Georgia Power Company
Mr H. L. Sumner, General Manager - Nuclear Plant
NOB

U.S. Nuclear Regulatory Commission, Washington, D.C.
Mr. K. Jabbour, Licensing Project Manager - Hatch

U.S. Nuclear Regulatory Commission, Region II
Mr. S. D. Ebneter, Regional Administrator
Mr. L. D. Wert, Senior Resident Inspecto - Hatch

ENCLOSURE 1

PLANT HATCH - UNITS 1, 2
NRC DOCKETS 50-321, 50-366
OPERATING LICENSES DPR-57, NPF-5
VIOLATION 92-08-01 AND GPC RESPONSE

VIOLATION 321,366/92-08-01

10 CFR 50 Appendix B Criterion III, Design Control, requires, in part, measures to be established to assure that applicable regulatory requirements and the design basis for safety related structures, systems, and components are correctly translated into specifications, drawings, procedures, and instructions.

Contrary to the above, requirements were not correctly translated in the following examples:

1. The drawings of the control circuitry of numerous safety related motor operated valves were incorrect. The status of permanent bypasses around the thermal overload trip function on the valves was unknown by the licensee. The overloads of several valves which should have had bypasses installed did not. These conditions have existed for several years.

2. The Instrument Setpoint Index document contains incorrect safety related level switch setpoints. For an undetermined period of time, a number of elevation values listed as setpoints for the level switches have been incorrect.

This is a severity level IV violation (Supplement I).

RESPONSE TO VIOLATION

Admission or Denial of the Violation

The two examples cited in the Notice of Violation are discussed below:

Example 1:

Example 1 is considered a violation and occurred as described in the Notice of Violation. Several motor operated valves (MOVs) which should have had permanent bypass jumpers installed around the thermal overload (TOL) trip function, in fact, did not.

During drawing reviews associated with the Generic Letter 89-10 program, GPC identified a concern regarding the status of permanent bypasses around TOLs. GPC identified 96 MOVs which could not be confirmed to have permanent bypasses installed. While the plant design drawings for these valves indicated jumpers were not installed, in some cases, vendor drawings indicated jumpers were

installed. Of the 96 MOVs, 39 are within the scope of 10 CFR 50.49. Drawings for the remaining 196 MOVs within the GL 89-10 program indicate that TOL jumpers are installed.

Prior to identifying the concern, it was generally believed the TOL devices had been permanently bypassed on all safety-related MOVs. The belief was a result of the statement in the Unit 2 FSAR, Section 8.3.1.1.2, that the overloads of "essential" MOVs are permanently bypassed, and the results of previous engineering reviews relative to TOL devices. Subsequent NRC guidance contained in Reg Guide 1.106 allowed defeating the TOL device; however, GPC has no specific commitment to this Reg Guide.

REASON FOR THE VIOLATION

The violation was caused by less than adequate clarity within the design drawings relative to indicating the internal control wiring for the bypass jumpers. The control wiring is specified on plant drawings through the use of typical diagrams. The use of typical diagrams is representative of standard design practices at the time Plant Hatch was constructed. However, the typical diagram representations and notes are complex and drawing misinterpretations have resulted. As a result, it was not readily apparent whether TOL devices were bypassed.

A contributing cause to the violation was the lack of a clear definition of "essential MOVs" within the FSARs. Consequently, the requirements for permanent bypasses have not been consistently interpreted and applied during previous engineering reviews.

GPC recognizes that previous engineering studies involving this subject resulted in incorrect conclusions relative to the status of the actual MOV configurations for permanently bypassing TOL devices. The reviews did identify limited discrepancies and those specific discrepancies were corrected at that time. However, the reviews failed to recognize the full scope of the discrepancies between plant drawings and actual configurations. The full scope was identified by the more thorough and comprehensive engineering reviews performed under the Generic Letter 89-10 program.

Corrective Steps Which Have Been Taken and the Results Achieved

1. An operability analysis was performed for the 96 MOVs that do not have TOL jumpers indicated on the plant design drawings to justify continued operation assuming the TOL was not bypassed.

2. Walkdowns of the 39 MOVs within the scope of 10 CFR 50.49 to verify the actual configuration have been completed. The results showed that 25 MOVs did not have TOL devices jumpered.

3. DCR 92-075 has been implemented to install jumpers around the TOL devices of the 12 Unit 1 MOVs within the scope of 10 CFR 50.49.

4. A clear definition of essential MOVs has been developed. Essential MOVs are defined as those related to 1) emergency core cooling systems, 2) primary containment isolation systems, and 3) 10 CFR 50.49.

Corrective Steps Which Will be Taken to Avoid Further Violations

1. Permanent bypasses will be installed around the TOL devices of the 13 Unit 2 MOVs within the scope of 10 CFR 50.49. This action will be completed during the next outage of sufficient duration, but no later than the end of the Fall 1992 refueling outage.

2. Walkdowns will be performed to verify the configurations on the 57 non-EQ, safety-related MOVs which potentially have operative TOL devices. Jumpers will be verified to have been installed or will be installed consistent with the definition of essential. Those actions will be complete prior to startup from the Spring 1993 refueling outage for Unit 1 and prior to startup from the Fall 1992 refueling outage for Unit 2.

3. Applicable design drawings will be revised to reflect the results of the walkdowns and jumper installations. Additionally, appropriate design drawings will be revised to more clearly indicate jumpers across the TOL device. These actions will be complete by 8/30/93 for Unit 1 and 3/31/93 for Unit 2.

4. Because of the discrepancies identified, the remaining 196 safety-related MOVs will be walked down to validate the accuracy between plant design drawings and the installed configurations for these MOVs. As the TOL jumpers are indicated on the design drawings for these MOVs, the possibility of an operative TOL device is reduced. Also, recent walkdowns and inspections have not indicated any discrepancies for the remaining MOVs. The observed discrepancies have been limited to the 96 MOVs which do not indicate jumpers around the TOL device.

   The walkdown will be used to confirm the TOL configurations or to initiate appropriate corrective actions as required. The walkdown will be completed prior to startup from the Spring 1993 refueling outage for Unit 1 and prior to startup from the Fall 1992 refueling outage for Unit 2.

VIOLATION 92-08-01 AND GPC RESPONSE

Example 2:

Example 2 is considered a violation and occurred as described in the Notice of Violation. The elevation values listed for the emergency diesel generator day tank level switches are incorrect in that the values in the Setpoint Index are in error by nine inches.

Reason for the Violation

The violation was caused by personnel error. GPC's architect/engineering personnel incorrectly calculated the setpoint and did not provide an adequate review to detect the error.

The Setpoint Index for both units was originally issued on 4/22/83. Apparently, the error occurred when 130 feet, which is the floor elevation, was used instead of 130 feet 9 inches, which is the elevation for the bottom of the tank. However, the level switches associated with the error were correctly calibrated as I&C department personnel use scribe marks to calibrate the switches in accordance with approved plant procedures. Consequently, the day tanks contained the proper amount of fuel.

Corrective Steps Which Have Been Taken and the Results Achieved

1) A review of the setpoint discrepancies associated with the day tank level switches has been completed. The Level Setting Diagram was confirmed to list the correct values.

2) Procedure 57CP-CAL-094-2S, "Robertshaw Level Switch SL-200, SL-300, SL-400 and SL-700 Calibration," has been revised to correct the reference setpoint values associated with the day tank level switches.

Corrective Steps Which Will be Taken to Avoid Further Violations

A comparison between the Setpoint Index and the Level Setting Diagrams for both units will be performed to identify any further discrepancies. is activity will be completed by 5/30/92.

The identified discrepancies on safety-related instruments will be evaluated to determine the correct setpoint value. The Setpoint Index and/or Level Setting Diagram will be revised accordingly. These actions will be completed by 8/3/92.

VIOLATION 92-08-01 AND GPC RESPONSE

Calculations and calibration procedures will be reviewed and revised, as necessary, to incorporate the results of the setpoint discrepancy evaluations. These actions will be completed by 10/15/92.

Date When Full Compliance Will be Achieved

Full compliance will be achieved on 8/3/92 when the Setpoint Index and/or the Level Setting Diagrams are revised to correct errors in the setpoints for safety-related instruments.

ENCLOSURE 2

PLANT HATCH-UNIT 2
NRC DOCKET 50-366
OPERATING LICENSE NPF-5
VIOLATION 92-08-02 AND GPC RESPONSE

VIOLATION 92-C8-02

Hatch Unit 2 Technical Specification 6.8.1 requires that written procedures be established, implemented and maintained covering the activities recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978.

Item 9.a of Appendix A of Regulatory Guide 1.33 specifically recommends that maintenance that can affect the performance of safety-related equipment should be properly preplanned and performed in accordance with written procedures, documented instruction or drawings appropriate to the circumstances.

Contrary to the above, on March 16, 1992, maintenance personnel failed to perform work on the 2C1 (2Y52-C001C) diesel generator fuel oil transfer pump in accordance with the established Maintenance Work Order. Inadequate component identification resulted in the 2C2 (2Y52-C101C) fuel oil transfer pump being inappropriately removed from service. This rendered the 2C emergency diesel generator inoperable for 19 hours without the TS compensatory actions being completed.

This is a Severity Level IV Violation (Supplement 1).

This violation is applicable to Unit 2 only.

RESPONSE TO VIOLATION 92-08-02

Admission or denial of the violation:

The violation occurred as described in the Notice of Violation.

Reason for the Violation:

The violation was caused by personnel error. Maintenance department personnel did not use self verification techniques to ensure they were working on the correct diesel generator fuel oil transfer pump.

Fuel oil transfer pump 2Y52-C001C, one of the two 100% capacity pumps for diesel generator 2C, had been properly cleared for service on 3/15/92 by Operations Department personnel via an equipment clearance. This was done in accordance with approved plant procedures and the Unit 2 Technical Specifications so the pump could be overhauled under Maintenance Work Order 2-91-1058. On 3/16/92, Maintenance Department personnel mistakenly disconnected and removed fuel oil transfer pump 2Y52-C101C, the redundant fuel oil transfer pumps on diesel generator 2C. This left the diesel generator

with no operable fuel oil transfer pumps, contrary to the requirements of the Unit 2 Technical Specifications, until 3/17/92 when Maintenance Department personnel discovered their error while preparing to re-install the pump. At that time, Operations Department personnel returned fuel oil transfer pump 2Y52-C001C to service. However, diesel generator 2C was inoperable for 19 hours without the required Technical Specification compensatory actions having been taken.

Corrective Steps Which Have Been Taken and the Results Achieved:

The involved Maintenance Department personnel were counseled on their mistake and on proper identification of the pumps involved in this event. They were also retrained on verifying pieces of equipment by their Master Parts List tags.

Corrective Steps Which Will be Taken to Avoid Further Violations:

Training in self verification techniques will be given to the appropriate personnel in the Maintenance, Operations, Health Physics/Chemistry, and Engineering Support Departments. Operations personnel are receiving the training during the current segment of regularly scheduled continuing training. Training for the remaining departments will be completed by the end of 1992 as part of their respective continuing training.

Date When Full Compliance Will be Achieved:

Full compliance was achieved on 3/17/92 when one fuel oil transfer pump for diesel generator 2C was returned to an operable status as required by the Unit 2 Technical Specifications.